Washington State Health Care Authority
Public Employees Benefits Board

Your PEBB Benefits for 2014

Retiree Enrollment Guide

HCA 51-205 (12/13)

This booklet contains information you need about benefits, monthly premiums, and the plans available to you.

Important requirements to remember:

- **You have 60 days after the date your employer-paid or continuous COBRA coverage ends to enroll in or defer (postpone) PEBB retiree coverage.** If you don't complete and submit the *Retiree Coverage Election Form* within the required timeframe, you could lose your right to enroll.
- If entitled, you and/or your dependent(s) must enroll and maintain enrollment in both Medicare Part A and Part B to qualify for PEBB retiree coverage. If you don't, you and/or your dependent(s) will no longer be eligible for enrollment in PEBB retiree coverage.
- We will not enroll you until we receive your first premium payment unless you choose to have your premiums deducted from your monthly pension check.
- If you are a retiree and not entitled to Medicare, or enrolling a domestic partner, you must provide documents that verify your dependent's eligibility for PEBB retiree coverage or the dependent will not be enrolled.

If you want additional information about Public Employees Benefits Board (PEBB) coverage

Call the PEBB Program at 360-725-0440 or toll-free at 1-800-200-1004, Monday through Friday, 8 a.m. to 5 p.m.
For personal assistance, visit our office at 626 8th Avenue SE, Olympia, WA, 98501.
To send a fax, dial 360-725-0771.
Go to **www.hca.wa.gov/pebb** for forms, publications, and information updates.

Mail first premium payments to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Write to the PEBB Program at:

Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

For automatic bank account withdrawals of your monthly premium:

An *Electronic Debit Service Agreement* form is provided in the back of this booklet.

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004.
TTY users may call through the Washington Relay service by dialing 711.

Contact Information

Contact the health plans for help with:	Contact the PEBB Program at 1-800-200-1004 for help with:
• Specific benefit questions. • Verifying if your doctor or other provider contracts with the plan. • Verifying if your medications are listed in the plan's drug formulary. • ID cards. • Claims.	• Eligibility questions and changes (Medicare, divorce, etc.). • Changing your name, address, or phone number. • Adding or removing dependents. • Finding forms. • Eligibility complaints or appeals.

Medical plans	Website addresses	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Group Health Classic, Medicare, or Value **Group Health Options, Inc. (CDHP)**	**www.ghc.org/pebb**	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic, CDHP, or Senior Advantage	**www.my.kp.org/nw/wapebb**	503-813-2000 or 1-800-813-2000 Medicare members: 1-877-221-8221	1-800-735-2900
Medicare Supplement Plan F, administered by Premera Blue Cross	**www.premera.com**	1-800-817-3049	1-800-842-5357
Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield	**www.hca.wa.gov/ump**	1-888-849-3681	711

Dental Plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Delta Dental of Washington	**www.deltadentalwa.com/pebb**	1-800-650-1583
Uniform Dental Plan, administered by Delta Dental of Washington	**www.deltadentalwa.com/pebb**	1-800-537-3406
Willamette Dental of Washington, Inc.	**www.WillametteDental.com/WApebb**	1-855-433-6825

Health savings account trustee	Website address	Customer service phone number	TTY Customer service phone number (deaf, hard of hearing, or speech impaired)
HealthEquity, Inc.	**www.healthequity.net/pebb**	1-877-873-8823	711

VEBA Voluntary Employee Beneficiary Association Trust	Website address	Customer service phone number	TTY Customer service phone number (deaf, hard of hearing, or speech impaired)
Meritain Health	**www.veba.org**	1-888-828-4953	711

Life Insurance	ReliaStar Life Insurance Company	1-866-689-6990	
Long-Term Care Insurance	John Hancock Life Insurance Company (U.S.A.)	**www.hca.wa.gov/pebb/pages/ltc.aspx**	1-800-399-7271
Auto and Home Insurance	Liberty Mutual Insurance Company	**www.hca.wa.gov/pebb/pages/auto_home.aspx**	1-800-706-5525

PEBB Program is Saving the Green

Help reduce our reliance on paper mailings—and their toll on the environment—by signing up to receive PEBB mailings by email. To sign up, go to **www.hca.wa.gov/pebb** and select *My Account* under the *My PEBB* header in the left navigation panel.

Welcome to Retirement!

The Public Employees Benefits Board (PEBB) Program, administered by the Health Care Authority (HCA), is pleased to offer continued choice, access, value, and stability in benefits. The PEBB Program purchases and coordinates health insurance benefits for eligible public employees and retirees, so you can expect to receive competitive benefits from one of the largest health-care purchasers in the state.

Who determines the benefits?

The Legislature establishes how much state money is available to spend on benefits. Then the PEB Board establishes eligibility requirements and approves benefit designs for insurance and other benefits. The Board meets regularly to review benefit and eligibility issues, and plan for the future.

Who purchases the benefits?

The HCA purchases benefits within the funding approved by the Legislature. The HCA contracts with insurance companies and manages its own self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members.

Inside this booklet you will find…

- Information on who can enroll.
- Enrollment requirements.
- Monthly premiums.
- Basic information about your medical and dental coverage, life, long-term care, and auto and home insurance options.
- Plans available in your county.

The benefits comparisons in this guide are brief summaries. For more details about a plan's benefits, refer to the plan's certificate of coverage. You may request a copy of the certificate of coverage after you enroll, or you can find it on the plan's website. Some information described in this guide is based on federal or state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

The contents of this booklet are accurate at the time of printing. You may call the PEBB Program at 1-800-200-1004 for questions on eligibility or enrollment and you can go to **www.hca.wa.gov/pebb** for updates to laws or rules or to find more information. If you have questions not answered in this booklet, you can reach a benefits representative Monday through Friday between 8 a.m. and 5 p.m.

Where to find laws and rules

You can find the Public Employees Benefits Board's existing law in chapter 41.05 of the Revised Code of Washington, and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). A link to WAC is available on the *PEBB Rules and Policies* page of the PEBB website.

Table of Contents

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- See page 10 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Jane pays 20% | Her plan pays 80%

(See page 10 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Jane pays 100% | Her plan pays 0%

(See page 10 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit


(See page 10 for a detailed example.)

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

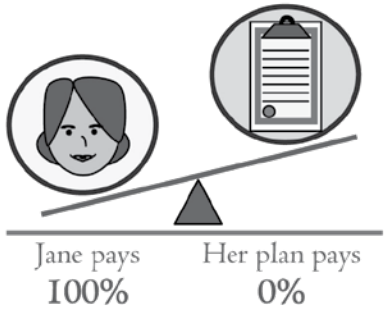
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

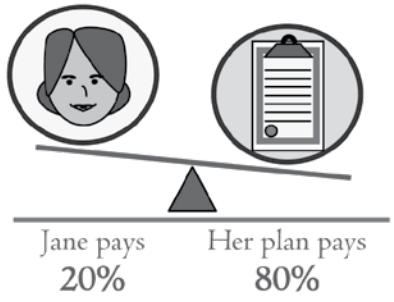
December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

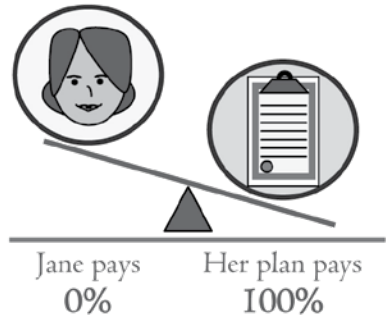
Office visit costs: $125
Jane pays: $125
Her plan pays: $0



Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

This page intentionally left blank.

2014 PEBB Retiree Monthly Premiums

Effective January 1, 2014 (See "Monthly Surcharges Effective July1, 2014" next page)

Special Requirements

1. To qualify for the Medicare rate, at least one covered family member must be enrolled in both Part A and Part B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan or Kaiser Permanente Senior Advantage must complete and sign the *Medicare Advantage Plan Election Form* (form C) to enroll in one of these plans. For more information on these requirements, contact your health plan's customer service department.

Medical Plans							
Members not eligible for Medicare (or enrolled in Part A only):	**Group Health Classic**	**Group Health Value**	**Group Health CDHP**	**Kaiser Permanente Classic**	**Kaiser Permanente CDHP**	**UMP Classic**	**UMP CDHP**
Subscriber Only	$ 589.19	$ 537.04	$ 500.69	$ 588.43	$ 503.93	$ 551.03	$ 504.56
Subscriber & Spouse*	1,172.16	1,067.86	992.20	1,170.64	998.18	1,095.84	999.94
Subscriber & Child(ren)	1,026.42	935.16	883.91	1,025.09	889.20	959.64	890.68
Full Family	1,609.39	1,465.98	1,317.09	1,607.30	1,325.12	1,504.45	1,327.73

Members enrolled in Part A & Part B of Medicare:	**Group Health Medicare Plan**	**Group Health Classic**	**Group Health Value**	**Kaiser Permanente Classic**	**UMP Classic**
Subscriber Only	$144.79	N/A‡	N/A‡	$ 152.99	$ 223.87
Subscriber & Spouse* (1 Medicare eligible)	N/A‡	$ 727.76	$ 675.61	735.20	768.68
Subscriber & Spouse* (2 Medicare eligible)	283.36	N/A‡	N/A‡	299.76	441.52
Subscriber & Child(ren) (1 Medicare eligible)	N/A‡	582.02	542.91	589.65	632.48
Subscriber & Child(ren) (2 Medicare eligible)	283.36	N/A‡	N/A‡	299.76	441.52
Full Family (1 Medicare eligible)	N/A‡	1,164.99	1,073.73	1,171.86	1,177.29
Full Family (2 Medicare eligible)	N/A‡	720.59	681.48	736.42	850.13
Full Family (3 Medicare eligible)	421.93	N/A‡	N/A‡	446.53	659.17

*** or state-registered domestic partner**

‡ If a Group Health subscriber is enrolled in Medicare Part A and Part B but covers a family member not eligible for Medicare, the family member must enroll in a Group Health Classic or Value plan and the subscriber pays a combined Medicare and non-Medicare rate.

Medicare Supplement Plan F, administered by Premera Blue Cross

	Plan F (Age 65 or older, eligible by age)	Plan F (Under age 65, eligible by disability)
Subscriber Only	$ 106.37	$ 196.74
Subscriber & Spouse* (1 Medicare eligible)**	651.18	741.55
Subscriber & Spouse* (2 Medicare eligible – 1 retired, 1 disabled)	296.89	296.89
Subscriber & Spouse* (2 Medicare eligible)	206.52	387.26
Subscriber & Child(ren) (1 Medicare eligible)**	514.98	605.35
Full Family (1 Medicare eligible)**	1,059.79	1,150.16
Full Family (2 Medicare eligible – 1 retired, 1 disabled)**	705.50	705.50
Full Family (2 Medicare eligible)**	615.13	795.87

***or state-registered domestic partner**

**** If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP) Classic. The rates shown reflect the total due, including premiums for both plans. Medicare rates shown above have been reduced by the state-funded contribution up to the lesser of $150 or 50 percent of plan premium per retiree per month.**

Monthly Surcharges Effective July 1, 2014

The following surcharges will be added to the medical plan premiums. **These surcharges do not apply if all enrolled family members are also enrolled in Medicare Part A and Part B.**

- A monthly $25-per-account surcharge will apply if the subscriber or one or more of the enrolled family members use tobacco products.
- A monthly $50 surcharge will apply if a subscriber enrolls a spouse or state-registered domestic partner, and the spouse or partner has waived enrollment in other employer-sponsored coverage that is comparable to PEBB medical coverage.

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan, administered by Washington Dental Service	Willamette Dental of Washington, Inc.
Subscriber Only	$ 39.53	$ 44.72	$ 43.23
Subscriber & Spouse*	79.06	89.44	86.46
Subscriber & Child(ren)	79.06	89.44	86.46
Full Family	118.59	134.16	129.69

***or state-registered domestic partner**

Retiree Life Insurance Self-Pay Rate – $6.57 per month

Eligibility Summary

Who is eligible for PEBB coverage?

This guide provides a general summary of PEBB retiree eligibility. The PEBB Program will determine your eligibility at the time of your application and based on PEBB rules. If you disagree with the determination, see "How can I appeal a decision?" on page 16.

Find it here

For complete details on PEBB eligibility and enrollment, refer to Washington Administrative Code (WAC), chapter 182-12. You can find these in the *PEBB Rules and Policies* page at **www.hca.wa.gov/pebb**

You may be eligible to enroll in PEBB plans if you are a retiring employee of a:

- State agency
- State higher education institution
- K-12 school district or educational service district
- PEBB-participating employer group

You may also be eligible to enroll in PEBB retiree insurance if you are an elected or full-time appointed state official (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leaves public office.

To be eligible to enroll in PEBB retiree insurance, you must meet both the procedural requirements and the eligibility requirements of WAC 182-12-171.

Procedural requirements include:

- You must submit a *Retiree Coverage Election Form* (form A) to enroll or defer enrollment in retiree insurance coverage no later than 60 days after your employer-paid or COBRA coverage ends.
- If you or a dependent you wish to enroll is entitled to Medicare and your retirement date is after July 1, 1991, you must enroll in and maintain enrollment in Medicare Part A and Part B.

See important information about deferring retiree insurance coverage on page 24.

In general, the eligibility requirements are:

You must be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid or COBRA coverage ends (unless you are an elected or appointed state official as defined under WAC 182-12-114(4)). The following are Washington State-sponsored retirement plans:

- Public Employees Retirement System (PERS) 1, 2, or 3
- Public Safety Employees Retirement System (PSERS)
- Teachers Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (for example, TIAA-CREF)
- School Employees Retirement System (SERS) 2 and 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System
- Civil Service Retirement System and Federal Employees' Retirement System are considered a Washington State-sponsored retirement system for Washington State University Extension employees covered under PEBB insurance at the time of retirement or disability.

You must immediately begin to receive a monthly retirement plan payment, with the following exceptions:

- If you receive a lump sum payment instead of a monthly retirement plan payment, you are only eligible if the Department of Retirement Systems offered you the choice between a lump sum equivalent payment and an ongoing monthly payment.
- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3 and you meet the retirement plan's eligibility criteria when your employer-paid or COBRA coverage ends, you do not have to receive a monthly retirement plan payment.
- If you are an employee retiring under a Washington State higher education retirement plan (such as TIAA-CREF) and you meet your retirement plan's eligibility criteria or you are at least age 55 with 10 years of state service, you do not have to receive a monthly retirement plan payment.
- If you are an employee retiring from a PEBB-participating employer group and your employer does not participate in a Washington State-sponsored retirement system, you do not have to receive a monthly retirement plan payment. However, you do

have to meet the same age and years of service as if you had been employed as a member of either PERS Plan 1 or PERS Plan 2 for the same period of employment.

- If you are an elected or full-time appointed official of the legislative or executive branches of state government (as defined under WAC 182-12-114(4)), you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a state-sponsored retirement system.

Can I cover my family members?

You may enroll the following family members (as described in WAC 182-12-260):

- Your lawful spouse.
- Your domestic partner. Effective January 1, 2010, this includes a state-registered domestic partner, or a domestic partner who qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under your PEBB health plan or PEBB life insurance.
- Your children. Children are eligible up to age 26, except as described below for children with a disability. Children are defined as your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption, children of your state-registered domestic partner, children specified in a court order or divorce decree, or children defined in state statutes that establish the parent-child relationship.

In addition, children include extended dependents in your spouse's or your domestic partner's legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or domestic partner have legal responsibility as shown by a valid court order and the child's official residence with the custodian or guardian. This does not include foster children for whom support payments are made to you through the state Department of Social and Health Services (DSHS) foster care program.

Eligible children also include children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing care, provided the condition occurred before age 26. You must provide evidence of the disability and evidence the condition occurred before age 26. The PEBB Program will verify the disability and dependency of a child with a disability periodically beginning at age 26.

A child with a developmental disability or physical handicap who becomes self-supporting is not eligible as a child as of the last day of the month he or she becomes capable of self-support. If the child becomes capable of self-support and later becomes incapable of self-support, the child does not regain eligibility as a child with a disability.

If adding an extended dependent or a dependent with a disability you must complete and submit the appropriate dependent certification form in addition to your enrollment form. You can find the forms at **www.hca.wa.gov/pebb.**

The PEBB Program verifies the eligibility of all dependents and reserves the right to request proof of a dependent's eligibility. You must notify the PEBB Program in writing **no later than 60 days** after your dependent is no longer eligible.

The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 49.

If I die, are my surviving dependents eligible?

As an eligible employee or retiree, your surviving dependents may be eligible to enroll in PEBB retiree insurance if they meet both the procedural requirements and the eligibility requirements outlined in WAC 182-12-265.

Eligibility for dependents of emergency service employees

If you are a surviving dependent of an emergency service employee who was killed in the line of duty, you may be eligible to enroll in PEBB retiree insurance if you meet both the procedural and eligibility requirements outlined in WAC 182-12-250.

PEBB Appeals

How can I appeal a decision?

If you or your dependent disagrees with a specific decision or denial, you or your dependent may file an appeal.

If you are…	…and your appeal concerns:	You must:
• A retiree • A surviving spouse or state-registered domestic partner • The dependent of one of the above	A decision or action by the PEBB Program about eligibility for benefits, enrollment, or premium payments.	Submit your appeal to the PEBB Appeals Manager **no later than 60 days** from the date of the PEBB Program's denial of the decision or action you are appealing. Send appeals to: **Health Care Authority** **PEBB Appeals** **P.O. Box 42684** **Olympia, WA 98504-2684**
	A decision or action by a health plan or insurance carrier about a claim or benefit (such as a dispute about a course of treatment or billing).	Contact the health plan or insurance carrier to request information on how to appeal its decision or action.

You will find guidance on filing an appeal in chapter 182-16 WAC and at **www.hca.wa.gov/pebb** or you can call the PEBB appeals manager at 1-800-351-6827.

How can I make sure my personal representative has access to my health information?

You must provide us with a copy of a valid power of attorney or a completed *Authorization for Release of Information* form naming your representative and authorizing him or her to access your medical records and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at **www.hca.wa.gov/pebb** or by calling the PEBB Program at 1-800-200-1004.

How do I enroll?

It's important to submit your forms within the required timelines. As noted in the *Eligibility Summary*, you must enroll or defer coverage by submitting a *Retiree Coverage Election Form* (form A) **no later than 60 days** after your employer-paid or COBRA coverage ends. If you miss that 60-day window, you lose all rights to enroll in PEBB retiree coverage in the future unless you regain eligibility. To regain eligibility, you would have to return to work in a PEBB or K-12 benefits-eligible position and at the time of termination meet the enrollment and eligibility requirements of WAC 182-12-171.

Submit your completed *Retiree Coverage Election Form* (form A) and any other required forms to the PEBB Program as instructed on the form (found in the back of this guide). Submit form A even if you decide to defer your enrollment. See "Deferring Your Coverage" on page 24 for more information.

Include any eligible dependents you wish to enroll on the form(s). If you are a non-Medicare retiree or adding a state-registered domestic partner you must provide proof of your dependents' eligibility within PEBB's enrollment timelines or the family members will not be enrolled. See page 49 for a list of documents required to verify dependents.

If the Department of Retirement Systems (DRS) determines that you are retroactively eligible for a pension benefit due to disability, or the appropriate higher education authority determines that you are retroactively eligible for a supplemental retirement plan benefit under the Higher Education Retirement Plan due to disability, you may either enroll retroactive to the date of eligibility for retirement, or prospective from the date on the award notice sent to you.

You must send your first payment when you enroll, unless you choose to have your premiums deducted from your monthly pension check. Make your check for the premium payable to the Health Care Authority.

If you enroll, you must pay premiums back to the date when your other coverage ended. For example, if your other coverage ends in December, but you don't submit your enrollment form until February, you must pay January and February premiums to enroll in PEBB coverage.

Can I enroll on two PEBB accounts?

If you and your spouse or state-registered domestic partner are both independently eligible for PEBB coverage, you need to decide which of you will cover yourselves and any eligible children on your medical or dental plans. An enrolled family member may be enrolled in only one medical or dental plan. You could defer the medical coverage for yourself (see "Deferring Your Coverage" on page 24) and enroll as a dependent on your spouse's or domestic partner's medical coverage.

How long does the enrollment process take?

If you are retiring as a **state employee or a higher education institution employee**, here's what you can expect after you send your form(s) to us:

1. In most cases, your employer's payroll office will cancel your employee coverage when they process your final paycheck. We cannot enroll you in retiree coverage until this occurs.
2. The health plan(s) that covered you as an employee will send you a cancellation letter after your payroll office cancels your employee coverage. Federal rules require us to send you a *PEBB Continuation of Coverage Election Notice* booklet; keep it for future reference.
3. If your application is incomplete, we will send you a letter requesting more information. In most cases, your retiree coverage begins immediately after your current coverage ends.
4. Once your payroll office cancels your employee coverage and we receive any requested additional information, we will enroll you in PEBB retiree health coverage.
5. After we enroll you, your health plan(s) will send you a welcome packet.

If you are a K-12 retiree and meet PEBB eligibility and enrollment requirements, your coverage begins the first of the month after your school district or COBRA coverage ends.

continued

When does coverage begin?

When newly eligible—Medical, dental, and term life insurance coverage will begin on the first day of the month after employer-paid or COBRA coverage ends, as long as the appropriate forms are returned **no later than 60 days** after this coverage ends.

When making a change during annual open enrollment or when a special open enrollment event occurs—Coverage will begin as noted in the table below. You must submit the appropriate form(s) either during the annual open enrollment or **no later than 60 days** after the special open enrollment event. In many instances, the date you turn in your form affects the date that coverage begins. You may want to turn in your form sooner. See "What is a special open enrollment?" on page 23 for more information.

Annual event	When coverage begins
Open enrollment	January 1 of the following year
Special open enrollment events	**When coverage begins**
Marriage or establishment of a state-registered domestic partnership	The first day of the month after the date of the event or the date the PEBB Program receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day.
Birth or adoption	The date of birth (newborn children) or the date you assume legal obligation for the child's support in anticipation of adoption. **Note:** If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for the full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th, the higher premium will begin the next month. If you add your eligible spouse or state-registered domestic partner to your PEBB coverage due to your child's birth or adoption, his or her medical coverage begins the first day of the month in which the birth or adoption occurs.
Child becomes eligible as a dependent with a disability, or an extended dependent	The first day of the month after eligibility certification.
Other events that create a special open enrollment (see page 23)	The first day of the month after the event date or the date the PEBB Program receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day. **Note:** To be eligible for enrollment, dependents who experience an event that creates a special open enrollment must enroll in a PEBB plan **no later than 60 days** after the event. The PEBB Program requires proof of the event that created the special open enrollment.

What if I'm entitled to Medicare?

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B to remain eligible for PEBB retiree coverage.

Once you or your covered dependent(s) enrolls in Medicare Part A and Part B, you must send us a copy of either the Medicare card(s) or a letter from the Social Security Administration that shows the effective date of Medicare Part A and Part B coverage. Medicare will become the primary insurer for Medicare covered services, and the PEBB medical plan becomes secondary. Mail a photocopy of the Medicare card or letter to:

Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

We will update your account to reduce your premium to the lower Medicare rate, if applicable, and notify your health plan of your Medicare enrollment.

Entitlement to Medicare also qualifies as a special open enrollment event, allowing you to change your health plans. See "What is a special open enrollment" on page 23.

CDHPs and Medicare don't mix

If you are enrolled in a consumer-directed health plan with a health savings account (HSA) when you or your covered dependent(s) become entitled to Medicare Part A and Part B, you must take action to change your coverage **no later than 60 days** after you or your spouse enroll in Medicare Part A and Part B.

If a covered family member becomes entitled to Medicare Part A or Part B, the subscriber must either:

- Remove the family member from PEBB coverage **no later than 60 days** after enrolling in Medicare Part A and Part B, **or**
- Choose a new health plan. Your annual deductible and annual out-of-pocket maximum will restart with your new plan. You can keep the HSA, but you and the PEBB Program can no longer contribute to it. Contact HealthEquity, the HSA trustee, about any balance requirements and account fees.

If you are enrolled in Medicaid, you cannot enroll in a CDHP. Other exclusions apply.

Read more about PEBB Medicare plans

What you may need to know about Medicare Advantage and Medicare Supplement plans on page 31.

Find which counties Medicare Advantage plans are available in on pages 33-34.

See the "Medicare Plan Benefits Comparison" on pages 38-39.

See the "Outline of Medicare Supplement Coverage" on pages 40-43.

continued

How much do the plans cost?

Please see the retiree rates (premiums) on pages 12-13. In addition to your monthly premium, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage available from each plan for details.

The HCA collects premiums for the full month, and will not prorate them for any reason, including when a member dies before the end of the month. Some subscribers must also pay a premium surcharge starting July 1, 2014:

- A monthly $25-per-account surcharge will apply if you or one of your enrolled family members uses tobacco products.
- A monthly $50 surcharge will apply if you enroll your spouse or state-registered domestic partner, and the spouse or partner has waived enrollment in other employer-sponsored coverage that is comparable to PEBB coverage.

These surcharges will not apply if all covered family members are enrolled in Medicare Part A and Part B.

How do I pay for coverage?

You can help ensure that your premium payments are made on time and avoid disruptions in your coverage by using pension deduction through the Department of Retirement Systems (DRS) or automatic bank account withdrawals. Here are your payment options:

- **DRS pension deduction** – Your premium is taken from your end-of-the-month pension check. For example, if your coverage takes effect January 1, your January 31 check will show your premium deduction for January.
- **Automatic bank account withdrawals** – You must complete and return the *Electronic Debit Service Agreement* form to the HCA. You can find the form in the back of this booklet. Approval takes six to eight weeks, so you must continue to pay your premium invoices until you receive a letter from the HCA with your electronic debit start date.
- **A personal check or money order** – Please make your check payable to Health Care Authority and send it with your election form to:

  Health Care Authority
  PO Box 42695
  Olympia, WA 98504-2695

Can I use a VEBA account?

If you have a Voluntary Employees' Beneficiary Association (VEBA) Trust account you must contact the VEBA administrator to request reimbursement for your premiums. The VEBA administrator cannot pay your monthly premiums directly to the PEBB Program. VEBA will not reimburse you for retiree term-life insurance. Remember to notify your VEBA administrator when your premiums change.

The administrator for VEBA is Meritain Health. Please call VEBA toll-free at 1-888-828-4953 for information, or visit **www.veba.org**.

Note: If you enroll in a consumer-directed health plan, you must elect limited VEBA plan coverage through the administrator; call Meritain Health for questions on how to do this.

What happens if I miss a premium payment?

You must pay the premiums for your PEBB coverage when due. If you pay late or do not pay in full, we will cancel your coverage at the end of the month in which we received the last full premium payment. If your insurance coverage is cancelled, coverage for your covered dependents also will be cancelled. You cannot enroll again in PEBB coverage unless you regain eligibility.

How do I add or remove dependents?

You may add eligible dependents or change your health plan election during the PEBB Program's annual open enrollment period. To do this you must complete and submit a *Retiree Coverage Election Form* with the dependent's information to the PEBB Program within the required time limits. If adding an extended dependent or a dependent with a disability, you must also submit the appropriate dependent certification form.

If you are a retiree not on Medicare and want to add a newly eligible dependent (a spouse or child) to your coverage, you must provide a copy of documents that prove the dependent's eligibility within the PEBB Program's enrollment time limits or the dependent will not be enrolled. All retirees must provide proof of dependent eligibility and submit the *Declaration of Tax Status* form to enroll a state-registered domestic partner.

Find it here

See page 49 for a list of documents the PEBB Program will accept as proof of dependent eligibility.

You can download and print dependent certification forms by going to **www.hca.wa.gov/pebb/pages/forms.aspx.**

Exception: If you want to enroll a newborn or child whom you have adopted (or assumed a legal obligation for total or partial support in anticipation of adoption), you should notify the PEBB Program by submitting a *Retiree Coverage Election Form* as soon as possible to ensure timely payment of claims. If adding the child increases your premium, you must submit the *Retiree Coverage Election Form* no later than 12 months after the date of birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Retiree subscribers may voluntarily remove an eligible dependent from coverage any time during the year. In most cases, the PEBB Program will remove the dependent from coverage prospectively.

Subscribers are required to notify the PEBB Program to remove dependents **no later than 60 days** from the date the dependent no longer meets the eligibility criteria described under WAC 182-12-260. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-170;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility; and
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.

What changes can I make during the annual open enrollment?

During the PEBB annual open enrollment you can:

- Change medical or dental plans.
- Enroll or remove eligible dependents from your coverage.
- Enroll in a health plan if you previously deferred PEBB retiree coverage for other coverage (See "Deferring Your Coverage" on page 24).
- Defer enrollment in PEBB retiree health coverage if you have or are enrolling in other coverage effective no later than January 1 of the following year. (See "Deferring Your Coverage" on page 24 for specific health coverage you can defer PEBB retiree coverage for.)

You must submit the appropriate form(s) to the PEBB Program before the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

What is a special open enrollment?

A retiree may change his or her health plan or add dependents when an event creates a special open enrollment. However, the change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent or both. **Note:** A retiree or surviving dependent may cancel a dependent's enrollment at any time.

To add a dependent, or change a medical or dental plan, the subscriber must submit the appropriate form(s) to the PEBB Program **no later than 60 days** after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program may require the subscriber to provide evidence of eligibility or evidence of the event that created the special open enrollment. The enrollment change will occur the first day of the month after the date of the event or the date the PEBB Program receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that date. Use the table below to see if the change you wish to make is allowed.

If this event happens...	These changes may be allowed:		
	Add dependent	Change medical plan	Change dental plan
Marriage or registering a domestic partnership	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption	Yes	Yes	Yes
Child becoming eligible as an extended dependent	Yes	Yes	Yes
Child becoming eligible as a dependent with a disability	Yes	Yes	Yes
Subscriber or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	Yes	Yes
Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage	Yes	Yes	Yes
Subscriber or dependent having a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment	Yes	No	No
Subscriber's dependent moving from outside the United States to live within the United States	Yes	No	No
Subscriber or dependent having a change in residence that affects health plan availability	No	Yes	Yes
A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent	Yes	Yes	Yes
Subscriber or a subscriber's dependent becoming entitled to coverage under Medicaid or CHIP, or losing eligibility for coverage under Medicaid or CHIP	Yes	Yes	Yes
Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state Children's Health Insurance Program (CHIP)	Yes	Yes	Yes
Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare; or enrolling, or canceling enrollment in a Medicare Part D plan	No	Yes	Yes
Subscriber's or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA)	No	Yes	Yes
Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program)	No	Yes	Yes

Deferring Your Coverage

Deferral rights for retirees

You may defer (postpone) your enrollment in PEBB retiree medical and dental coverage at or after retirement if continuously enrolled in other coverage as described below. If you defer enrollment in a PEBB retiree medical plan, you may not enroll in a PEBB dental plan. Except as stated below, if you defer enrollment in a PEBB health plan, you also defer enrollment for your dependents.

- If you are continuously enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if you are continuously enrolled in a comprehensive, employer-sponsored medical plan, including COBRA, as an employee or the dependent of an employee. This does not include an employer's retiree coverage.
- Beginning January 1, 2001, if you are continuously enrolled in medical coverage as a retiree or a dependent in a federal retiree plan, TRICARE, or the Federal Employees Health Benefits Program.
- Beginning January 1, 2006, if you are continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, your Medicaid coverage must include coverage for medical and hospital benefits. Your eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.
- Retirees who are not eligible for Medicare Part A and Part B may defer PEBB retiree coverage if enrolled in coverage offered through any health benefits exchange established under the Affordable Care Act. These retirees will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

To defer medical (or medical and dental) coverage, you must submit a *Retiree Coverage Election Form* (form A) to the PEBB Program:

- If you are an employee who is retiring, you must submit the form **no later than 60 days** after your employer-paid or COBRA coverage ends.
- If you are enrolled as a retiree, you must submit the form before you defer coverage.

Deferring retiree life insurance

If you have deferred your PEBB retiree health coverage and become eligible for the employer contribution toward PEBB life insurance (for example, by returning to state service), you may choose to either keep or cancel your retiree term life insurance. To do either, complete the *Life and AD&D Insurance Enrollment/ Change Form* and submit it to your employer's personnel, payroll, or benefits office. If you cancel your retiree term life insurance, you must complete the *Retiree Coverage Election Form* to reenroll in PEBB retiree term life insurance when you are no longer eligible for PEBB employer-sponsored benefits. You must submit this form to the PEBB Program **no later than 60 days** after your employer-paid coverage ends.

Deferral rights for surviving dependents of employees or retirees

A surviving dependent of an employee, a retiree, or a school district or educational service district employee who is eligible for PEBB retiree coverage under WAC 182-12-265 may defer enrollment under the circumstances listed below. If a surviving dependent defers enrollment in a PEBB retiree medical plan, he or she may not enroll in a PEBB dental plan.

- If a surviving dependent is continuously enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if a surviving dependent is continuously covered under another comprehensive, employer-sponsored medical plan, including COBRA, as an employee or the dependent of an employee.
- Beginning January 1, 2001, if a surviving dependent is continuously enrolled in medical coverage as a retiree or the dependent in a federal retirement plan, TRICARE or the Federal Employees Health Benefits Program.
- Beginning January 1, 2006, if a surviving dependent is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the surviving dependent's Medicaid coverage must

include coverage for medical and hospital benefits. A surviving dependent's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.

- Surviving retirees who are not eligible for Medicare Part A and Part B may defer PEBB retiree coverage if enrolled in coverage offered through any health benefits exchange established under the Affordable Care Act. These retirees will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Retirees who are not eligible for Medicare Part A and Part B may defer PEBB retiree coverage if enrolled in coverage offered through any health benefits exchange established under the Affordable Care Act. These retirees will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

To defer medical (or medical and dental) coverage, a surviving dependent must submit a *Retiree Coverage Election Form* to the PEBB Program:

- In the event of an employee or retiree's death, a surviving dependent must submit the form **no later than 60 days** after the death.
- If a surviving dependent enrolls in PEBB retiree coverage as a surviving dependent and is eligible to defer coverage in the future, he or she must submit the form before deferring coverage.

Deferral rights for surviving dependents of emergency services personnel

A surviving dependent of emergency services personnel killed in the line of duty who is eligible for PEBB retiree coverage under WAC 182-12-250 may defer enrollment under the circumstance listed below. If a surviving dependent defers enrollment in a PEBB retiree medical plan, he or she may not enroll in a PEBB dental plan.

Surviving dependent is continuously enrolled in comprehensive employer-sponsored medical plan including COBRA. The surviving dependent must submit a *Retiree Coverage Election Form* to the PEBB Program **no later than 180 days** after the later of:

- The death of the emergency service employee.
- The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
- The last day the surviving dependent was covered under a health plan through the emergency service employee's employer.
- The last day the surviving dependent was covered under COBRA coverage from the emergency service employee's employer as described in WAC 182-12-250.

How do I enroll after deferring PEBB coverage?

If a retiree or surviving dependent deferred enrollment in PEBB retiree coverage, he or she may reenroll under the following circumstances, as long as he or she has had continuous enrollment in other coverage defined earlier in this section.

- During any PEBB annual open enrollment.
- **No later than 60 days** after the date other coverage ends. Enrollment will begin the first day of the month after other coverage ends.

Although a retiree or survivor has 60 days to enroll, the retiree or survivor must pay PEBB premiums back to when other coverage ended.

To enroll, submit a *Retiree Coverage Election Form* and proof of continuous enrollment in other medical coverage to the PEBB Program. Proof must list when the coverage began and ended.

A retiree or surviving dependent has a one-time opportunity to enroll in PEBB medical and dental coverage if he or she deferred enrollment in PEBB coverage for federal retiree coverage.

A retiree has a one-time opportunity to enroll in PEBB medical and dental coverage if he or she deferred enrollment in PEBB coverage for coverage through a health benefits exchange established under the Affordable Care Act.

continued

How do I enroll after deferring PEBB coverage for Medicaid?

Retirees or surviving dependents who defer PEBB retiree coverage while continually enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage may enroll in PEBB coverage if they lose their Medicaid coverage:

- During any PEBB annual open enrollment.
- **No later than 60 days** after the date Medicaid coverage ends, or no later than the end of the calendar year when the retiree or survivor's Medicaid coverage ends, if he or she was also eligible under subsidized Medicare Part D.

Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the Department of Social and Health Services has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependent(s) in PEBB medical than a medical assistance program.

When PEBB Coverage Ends

How do I cancel coverage?

To cancel your PEBB retiree coverage, you must submit your request in writing to:

Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

In most cases, plan enrollment will end at the end of the month in which we receive your written request. If you are enrolled in a Medicare Advantage plan, you must also send a completed *PEBB Medicare Advantage Plan Disenrollment Form* (form D) to us. We will send form D to your plan, which will remove you from coverage on the first of the month after the plan receives the form.

If you cancel your PEBB retiree coverage, you cannot enroll again later unless you regain eligibility for PEBB coverage, for example, by returning to employment in a PEBB or K-12 benefits-eligible position.

When does PEBB coverage end?

PEBB insurance covers an entire month and must end as follows:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month that you last paid the full premium. The PEBB Program charges a full month's premium for each calendar month of coverage. The HCA will not prorate a premium if an enrollee dies or cancels his or her coverage before the end of the month.

What are my options when coverage ends?

You, your dependents, or both may temporarily continue your PEBB coverage by self-paying the premiums after your eligibility ends. Options for continuing coverage vary, based on the reason you lost eligibility.

The PEBB Program will mail a *PEBB Continuation of Coverage Election Notice* booklet to you or your dependent when retiree coverage ends. You or your eligible dependents must apply to the PEBB Program to continue coverage **no later than 60 days** after the mailing date on the *PEBB Continuation of Coverage Election Notice* booklet, or you will lose all rights to continue PEBB coverage.

Your dependents lose eligibility when you die; however, they may continue PEBB retiree coverage even if they were not covered at the time of your death. Your spouse or state-registered domestic partner may continue coverage indefinitely as long as he or she pays the premiums in full and on time. Your other dependents may continue coverage until they are no longer eligible under PEBB rules.

If your spouse is no longer eligible due to divorce, he or she may continue coverage for up to 36 months under COBRA.

If your state-registered domestic partnership ends, PEBB will offer your former domestic partner and his or her children an extension of coverage for up to 36 months.

If your dependent child is no longer eligible under PEBB rules, he or she may continue under COBRA for up to 36 months.

For information about your rights and obligations under PEBB rules and federal law, review the *PEBB Continuation of Coverage Election Notice* booklet.

How can I compare the plans?

All medical plans, except for Premera Blue Cross Medicare Supplement Plan F, cover the same basic health care services, but vary in other ways, such as provider networks, premiums, and drug formularies.

For example, the consumer-directed health plans (CDHPs) have the lowest monthly premiums, but they also have higher annual deductibles and higher out-of-pocket maximums.

Group Health and Kaiser Permanente are managed-care plans, while the Uniform Medical Plan (UMP) is a preferred-provider organization (PPO). A PPO is a health plan that allows you to self-refer to any approved provider type in most cases, but usually provides a higher reimbursement if the provider contracts with the plan. A managed-care plan requires you to select a primary care provider (PCP) within its network to fulfill or coordinate all of your health needs. The plan may not pay benefits if you see a non-contracted provider.

Find it here

See a side-by-side comparison of the plans' costs on page 35.

Use an interactive comparison tool, find links to each plan's website, or view a summary of benefits at **www.hca.wa.gov/pebb/**.

See premiums for all PEBB plans on pages 12-13.

Remember, if you cover eligible dependents, everyone must enroll in the same medical and dental plans. To choose a plan that best meets your needs, here are some things to consider:

Cost. Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plan F).

Your costs also include:

- **Deductible.** All medical plans, except Group Health's and Kaiser Permanente's Medicare Advantage plans, require you to pay an annual deductible before the plan pays for covered services. UMP Classic also has a separate annual deductible for some prescription drugs. Preventive care and certain other services are exempt from the medical plans' deductibles. This means it is not necessary for you to have met your deductible for the plan to cover the service.
- **Coinsurance or copays.** PEBB's managed-care plans require you to pay a fixed amount (called a copay) or percentage of an allowed fee (called a coinsurance) when you receive network care. UMP Classic and the CDHPs require members to pay coinsurance.
- **Out-of-pocket maximum.** The annual out-of-pocket maximum is the most you pay in a calendar year. Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges you incur during the year, such as your annual deductible, copays, and coinsurance, count toward your out-of-pocket maximum. However, here are a few costs that do not apply toward your annual out-of-pocket maximum:
  - Monthly premiums
  - Charges above what the plan pays for a benefit
  - Charges above the plan's allowed amount paid to a provider
  - Charges for services or treatments the plan doesn't cover
  - Coinsurance for non-network providers
  - Prescription-drug deductible and prescription-drug coinsurance (UMP Classic only)

Eligibility. You must be enrolled in Medicare Part A and Part B to enroll in the Medicare Advantage or Medicare Supplement plans. Also, not everyone qualifies to enroll in a CDHP with a health savings account (HSA). See "What do I need to know about the consumer-directed health plans?" on page 30.

Geography. In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on page 33. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.

Referral procedures. Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health-care services.

Your provider. If you have a long-term relationship with your doctor or health-care provider, you should verify whether he or she is in the plan's network. Contact the provider or plan before you join.

Your family members may choose the same provider, but it's not required. Each family member may select from any available provider in the plan's network. After you join a plan, you may change your provider, although the rules vary by plan.

Paperwork. In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members should also keep paperwork received from their provider or from qualified health care expenses to verify eligible payments or reimbursements from their health savings account.

Coordination with your other benefits. If you are also covered through your spouse's or domestic partner's comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits. All PEBB plans (except Premera Blue Cross Medicare Supplement Plan F) coordinate benefit payments with other group plans, Medicaid, and Medicare. This is called coordination of benefits (COB). This coordination ensures benefit costs are more fairly distributed when a person is covered by more than one plan.

Exception: PEBB plans that cover prescription drugs will not coordinate prescription-drug coverage with Medicare Part D. All PEBB plans cover prescription drugs except Premera Blue Cross Medicare Supplement Plan F. If you enroll in Medicare Part D, you must enroll in Medicare Supplement Plan F or lose your PEBB retiree coverage.

PEBB plans will not coordinate benefits with any individual health plan. This means how your PEBB plan pays for benefits will not change for a particular service or treatment, even if you or a dependent have an individual medical or dental policy covering that service or treatment.

You can compare some of the medical plans' benefits in this booklet (see pages 35-43) and at **www.hca.wa.gov/pebb**.

What type of plan should I select?

PEBB retirees may choose a managed-care plan, Medicare supplement plan, Medicare Advantage plan, consumer-directed health plan, or a preferred-provider plan. Your options are based on which plans are available in your county and whether you are enrolled in Medicare Part A and Part B.

Group Health Cooperative and Kaiser Permanente are managed-care plans. These plans require you to select a primary care provider (PCP) within its network to fulfill or coordinate all of your health needs. The plan may not pay for benefits if you see a non-contracted provider.

Uniform Medical Plan (UMP) is a preferred-provider organization (PPO) administered by Regence BlueShield. The plan is available anywhere in the world. Under this plan you can choose any provider and change providers at any time. However, when you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of the network.

continued

Medicare options:

- Group Health Medicare Plan (Medicare Advantage [Clear Care] or Original Medicare coordination plan)
- Kaiser Permanente Senior Advantage
- Medicare Supplement Plan F, administered by Premera Blue Cross
- UMP Classic (Medicare), administered by Regence BlueShield

Non-Medicare options:

Managed-care plans

- Group Health Classic
- Group Health Value
- Kaiser Permanente Classic

Consumer-directed health plans (CDHPs)

- Group Health Options, Inc. (CDHP)
- Kaiser Permanente CDHP
- UMP CDHP, administered by Regence BlueShield

Preferred-provider plan:

- UMP Classic, administered by Regence BlueShield

Generally, a classic plan has a higher premium than a value plan, but the classic plan's annual deductible, copays, or coinsurance are lower.

A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax-free. The CDHP has a lower monthly premium than most plans, with a higher deductible and a higher out-of-pocket maximum. Your medical deductible and your medical coinsurances and copays count toward your out-of-pocket maximum. **You cannot enroll in this plan if you are enrolled in Medicare. You cannot enroll your spouse or a dependent who is enrolled in Medicare.**

What do I need to know about the consumer-directed health plans?

You cannot enroll in a CDHP with a health savings account (HSA) if:

- You or your spouse or state-registered domestic partner is enrolled in Medicare or Medicaid.
- You are enrolled in another comprehensive medical plan—for example, on a spouse's or domestic partner's plan.
- You or your spouse or state-registered domestic partner is enrolled in VEBA, unless you convert it to a limited VEBA.
- You have received Veterans' Administration benefits (including prescription drugs) in the three months before you enroll in a CDHP/HSA, or have TRICARE coverage.
- You enrolled in a flexible spending account (FSA) or a health reimbursement arrangement (HRA). This also applies if your spouse has an FSA, even if you are not covering your spouse on your CDHP. This does not apply if the FSA or HRA is a limited purpose account, or for a post-deductible FSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply.

When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plan may not cover. See IRS Publication 969—for details.

The HSA is set up by your health plan with HealthEquity, Inc., to pay for or reimburse your costs for qualified medical services and expenses.

The PEBB Program contributes the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for the 2014 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled family members, up to $1,400.04 for the 2014 calendar year.

The contribution from the PEBB Program goes into the HSA in monthly installments over the year, and is deposited on the last day of each month. The entire annual amount is **not** deposited in your HSA on January 1.

You can also choose to contribute to your HSA through direct deposits to HealthEquity, and you may be able to deduct your HSA contributions from your federal income taxes.

In 2014, the annual HSA contribution limit is $3,300 (individuals) and $6,550 (you and one or more family members). If you are age 55 or above, you may contribute up to $1,000 more annually in addition to these limits. To ensure you do not go beyond the maximum allowable limit, make sure to calculate **both** the PEBB Program's contribution amount for the year and any amount you contribute.

Some other features of the CDHP/HSA:

- If you cover one or more family members, you must pay the entire family deductible before the CDHP begins paying benefits.
- Your prescription-drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in the Group Health Options or Kaiser Permanente CDHP.
- Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

What do I need to know about the Medicare Advantage and Medicare Supplement plans?

Medicare Advantage plans are available from Group Health and Kaiser Permanente, but are not available in every county. (See pages 33-34.) When these medical plans offer a Medicare Advantage plan in your county, and you are enrolled in Medicare Part A and Part B, you must enroll in the Medicare Advantage plan.

These plans contract with Medicare to provide all Medicare-covered benefits; however, most also cover the deductibles, coinsurance, and additional benefits not covered by Medicare. Neither the health plan nor Medicare will pay for services received outside of the plan's network except for authorized referrals and emergency care.

Group Health also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Group Health Medicare Advantage plan (marketed as Clear Care).

Medicare Supplement Plan F, administered by Premera Blue Cross, allows the use of any Medicare-contracted physician or hospital nationwide. The plan is designed to supplement your Medicare coverage by reducing your out-of-pocket expenses and providing additional benefits. It pays some Medicare deductibles and coinsurances, but primarily supplements only those services covered by Medicare.

The PEBB Program does not offer the high-deductible Plan F shown in the *Outline of Medicare Supplement Coverage* that begins on page 40.

In Medicare Supplement Plan F, benefits such as vision, hearing exams, and routine physical exams may have limited coverage or may not be covered at all.

If you select Medicare Supplement Plan F, any eligible family members who are not entitled to Medicare will be enrolled in UMP Classic.

How do PEBB plans with prescription-drug coverage compare to Medicare Part D?

All PEBB medical plans, except Premera Blue Cross Medicare Supplement Plan F, have prescription-drug coverage that is "creditable coverage." That means it is as good or better than the standard Medicare prescription-drug coverage (Medicare Part D). So:

- Your plan, on average for all plan members, meets at least what the standard Medicare prescription-drug coverage will pay.
- You can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in Medicare prescription-drug coverage later.
- You can enroll in a Medicare Part D plan when you first become entitled to Medicare, during the Medicare Part D open enrollment, and after you lose creditable prescription-drug coverage through your current plan. Open enrollment for Medicare Part D occurs toward the end of the year. However, joining Medicare Part D may affect your enrollment in the PEBB Program.

The PEBB Program does not offer Medicare Part D. You do not have to enroll in Medicare Part D. If you do enroll in Medicare Part D, the only PEBB medical plan that coordinates benefits with Medicare Part D is Premera Blue Cross Medicare Supplement Plan F. If you are enrolled in any other PEBB medical plan, you cannot enroll in Medicare Part D and keep your PEBB coverage.

How to Find the Summaries of Benefits and Coverage

For 2014, the Federal Patient Protection and Affordable Care Act requires the PEBB Program and health plans to provide a standardized comparison tool of medical plan benefits, terms, and conditions. This tool, called the Summary of Benefits and Coverage (or SBC), allows plan applicants and members to compare things like:

- What is not included in the plan's out-of-pocket limit?
- Do I need a referral to see a specialist?
- Are there services this plan doesn't cover?

The PEBB Program and/or medical plans must provide an SBC (or explain how to get one) at different times throughout the year, such as when someone applies for coverage, upon plan renewal, and when requested. The SBC is available upon request in Spanish, Tagalog, Chinese, and Navajo.

If you want to request an SBC from your current PEBB medical plan	If you want to request an SBC from another PEBB medical plan
You can either: • Go to your plan's website to view it online; OR • Call your plan's customer services to request a paper copy at no charge.	You can either: • Go to the plan's website to view it online; OR • Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.
You can find the medical plans' websites and customer service phone numbers on page 3.	

2014 Medical Plans Available by County

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the plan(s) you are interested in to ask about provider availability in your county.

Washington

Group Health Classic **Group Health Options, Inc. consumer-directed health plan** **Group Health Value** *These plans not available to Medicare members.*	• Benton • Columbia • Franklin • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Kittitas	• Lewis • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) • Mason • Pend Oreille (ZIP Code 99009) • Pierce • San Juan • Skagit • Snohomish	• Spokane • Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173) • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Group Health Medicare Advantage	• Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Lewis	• Mason (ZIP Codes 98312, 98524, 98528, 98541, 98546, 98548, 98555, 98560, 98584, 98588, and 98592)	• Pierce • San Juan • Skagit • Snohomish • Spokane • Thurston • Whatcom
Group Health Original Medicare	• Benton • Columbia • Franklin • Kittitas • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)	• Mason* • Pend Oreille (ZIP Code 99009) • Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)	• Walla Walla • Whitman • Yakima **Original Medicare is available in ZIP Codes where Medicare Advantage is not available.*
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan** *These plans not available to Medicare members.*	• Clark • Cowlitz • Lewis (ZIP Codes 98591, 98593, and 98596)	• Skamania (ZIP Codes 98639, 98648, and 98671)	• Wahkiakum (ZIP Codes 98612 and 98647)
Kaiser Permanente Senior Advantage	• Clark • Cowlitz	• Lewis (ZIP Codes 98591, 98593, and 98596) • Skamania	• Wahkiakum (ZIP Codes 98612 and 98647)
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in all Washington counties and nationwide.		
UMP Classic **UMP consumer-directed health plan** **UMP Medicare**	Available in all Washington counties and worldwide.		

continued

Oregon

Group Health Classic **Group Health Options, Inc. consumer-directed health plan** **Group Health Original Medicare** **Group Health Value**	• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)		
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan** *These plans not available to Medicare members.*	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055,	97067, 97068, 97070, 97086, 97089, 97222, and 97267-69) • Columbia • Hood River (ZIP Code 97014) • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389) • Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137,	97301-12, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392) • Multnomah • Polk • Washington • Yamhill
Kaiser Permanente Senior Advantage	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas • Columbia	• Hood River • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389)	• Marion • Multnomah • Polk • Washington • Yamhill
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in all Oregon counties and nationwide.		
UMP Classic **UMP consumer-directed health plan** **UMP Medicare**	Available in all Oregon counties and worldwide.		

Idaho

Group Health Classic **Group Health Options, Inc. consumer-directed health plan** **Group Health Original Medicare** **Group Health Value**	• Kootenai • Latah		
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in all Idaho counties and nationwide.		
UMP Classic **UMP consumer-directed health plan** **UMP Medicare**	Available in all Idaho counties and worldwide.		

2014 Medical Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

Annual Costs	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Deductible Applies to out-of-pocket maximum	$250/person $750/family	$350/person $1,050/ family	$1,400/person $2,800/family*		$250/person $750/family	$1,400/ person $2,800/ family*	$250/person $750/family	$1,400/ person $2,800/ family*
Out-of-pocket maximum[1]	$2,000/person $4,000/family Your deductible, copays and coinsurance for all covered services apply		$5,100/person $10,200/family** Your deductible, copays, and coinsurance for all covered services apply		$2,000/ person $4,000/family Your deductible, copays, and coinsurance for most covered services (not prescription-drug costs) apply	$4,200/ person $8,400/ family** Your deductible, copays, and coinsurance for most covered services apply	$2,000/ person $4,000/ family Your deductible, copays, and coinsurance for most covered services (not prescription-drug costs and prescription-drug deductible) apply	$4,200/ person $8,400/ family** All copays and coinsurance for covered services apply
Prescription drug deductible	None	None	Prescription-drug costs apply toward CDHP deductible.		None	Prescription-drug costs apply toward CDHP deductible.	$100/person $300/family (Tier 2 and 3 drugs)	Prescription-drug costs apply toward CDHP deductible.

*Must meet family deductible before plan pays benefits.

**Must meet family out-of-pocket maximum before plan pays 100% for covered benefits.

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP), and charges for non-covered services do not apply to out-of-pocket maximum. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and its affiliated providers, and any other licensed provider in the U.S.

[3] UMP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services plus any amount the provider charges over the allowed amount.

[4] Preventive care is not covered in Group Health's CDHP Extended Network except for routine mammography screening. Annual deductible and 30% plan coinsurance applies.

[5] Contact your plan about costs for children's vision care.

The information in this document is accurate at the time of printing. Contact the plans or review the certificate of coverage before making decisions.

continued

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Ambulance Air or ground, per trip	20%	20%	10%	30%	15%	15%	20%	20%
Diagnostic tests, laboratory, and x-rays	$0; MRI/ CT/PET scan $30	$0; MRI/ CT/PET scan $40	10%	30%	$10	15%	15%	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	10%	30%	20%	20%	15%	15%
Emergency room (copay waived if admitted)	$250	$300	10%	10%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$30	$30	$0	15%
Hardware	Any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.							
Home health	$0	$0	10%	30%	15%	15%	15%	15%
Hospital services Inpatient	$150/day up to $750 maximum/ admission	$200/day up to $1,000 maximum/ admission	10%	30%	15%	15%	$200/day up to $600 maximum/ year per person + 15% professional fees	15%
Outpatient	$150	$200	10%	30%	15%	15%	15%	15%
Office visit								
Primary care	$15	$20	10%	30%	$20	$20	15%	15%
Urgent care	$15	$20	10%	30%	$40	$40	15%	15%
Specialist	$30	$40	10%	30%	$30	$30	15%	15%
Mental health	$15	$20	10%	30%	$20	$20	15%	15%
Chemotherapy	$15	$20	10%	30%	$0	$0	15%	15%
Radiation	$30	$40	10%	30%	$0	$0	15%	15%
Physical, occupational, and speech therapy (per-visit cost for 60 visits/ year combined)	$15	$20	10%	30%	$30	$30	15%	15%

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Prescription drugs								
Retail pharmacy (up to a 30-day supply)								
Value tier	$5	$5	$5	$5	Does not apply	Does not apply	5% (up to $10/ 30-day supply)	
Tier 1	$20	$20	$20	$20	$15	$15	10% (up to $25/ 30-day supply)	15%*
Tier 2	$40	$40	$40	$40	$30	$30	30% (up to $75/30-day supply)	
Tier 3	50% up to $250	50% up to $250	50% up to $250	50% up to $250	Does not apply	Does not apply	50%* (Specialty drugs up to $150; no limit for non-specialty	
Mail order (up to a 90-day supply)								
Value tier	$10	$10	$10	Does not apply	Does not apply	Does not apply	5% (up to $30/ 90-day supply)	
Tier 1	$40	$40	$40	Does not apply	$30	$30	10% (up to $75/ 90-day supply)	
Tier 2	$80	$80	$80	Does not apply	$60	$60	30% (up to $225/ 90-day supply)	15%*
Tier 3	50% up to $750	50% up to $750	50% up to $750	Does not apply	Does not apply	Does not apply	50%* (specialty drugs up to $150; no limit for non-specialty)	
Preventive care	$0	$0	$0	Not covered[4]	$0	$0	$0	$0
See certificate of coverage or check with plan for full list of services.								
Spinal manipulations	$15	$20	10%	30%	$30	$30	15%	15%
Vision care[5] Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. Exception: for UMP Classic any amount over $65 for contact lens fitting fees.							

2014 Medicare Plan Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Group Health and Kaiser Permanente offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

Annual Costs	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Deductible	$0	$250/person $750/family	$0	$250/person $750/family
Out-of-pocket maximum[1]	$2,500/person Your copays and coinsurance for most covered services apply (except prescription-drug costs)	$2,000/person Your deductible, copays, and coinsurance for all covered services apply	$1,500/person Your copays and coinsurance for most covered services apply (except prescription-drug costs)	$2,500/person $5,000/family Your deductible, copays, and coinsurance for most covered services apply (except prescription-drug costs)
Prescription-drug deductible	None	None	None	$100/person $300/family (Tier 2 and 3 drugs)

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (Coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Ambulance Per trip, air or ground	$150	20%	$50	20%
Diagnostic tests, laboratory, and x-rays	$0	$0 MRI/CT/PET scan $30	$0	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	$0	15%
Emergency room Copay waived if admitted	$65	$250	$50	$75 copay + 15%
Hearing				
Routine annual exam	$20	$15	$30	$0
Hardware	Any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.			
Hospital services				
Inpatient	$200/day for first 5 days, up to $1,000 maximum/ admission	$150/day, up to $750 maximum/ admission	$500/admission	$200/day, up to $600 maximum/ admission + 15% professional fees
Outpatient	$200	$150	$50	15%

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (Coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Office visit				
Primary care	$20	$15	$30	15%
Urgent care	$20	$15	$35	15%
Specialist	$20	$30	$30	15%
Mental health	$20	$15	$30	15%
Chemotherapy	$0	$15	$0	15%
Radiation	$0	$30	$0	15%
Physical, occupational, and speech therapy	$20	$15 (Per-visit cost for 60 visits/year combined)	$30	15%
Prescription drugs				
Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies				
Value tier	Does not apply	$5	Does not apply	5% (up to $10/ 30-day supply)
Tier 1	$20	$20	$20	10% (up to $25/ 30-day supply)
Tier 2	$40	$40	$40	30% (up to $75/ 30-day supply)
Tier 3	50% up to $250	50% up to $250	Does not apply	50%
Mail order (up to a 90-day supply)				
Value tier	Does not apply	$10	Does not apply	5% (up to $30/ 90-day supply)
Tier 1	$40	$40	$40	10% (up to $75/ 90-day supply)
Tier 2	$80	$80	$80	30% (up to $225/ 90-day supply)
Tier 3	50% up to $750	50% up to $750	Does not apply	50% (specialty drugs up to $150; no limit for non-specialty)
Preventive care	$0	$0	$0	$0
	See certificate of coverage or check with plan for full list of services.			
Spinal manipulations	$20	$15	$20	15%
Vision care[2]				
Exam (annual)	$20	$15	$30	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. Exception: For UMP Classic, any amount over $65 for contact lens fitting fees.			

[1] Premiums, charges for services in excess of a benefit, charges in excess of allowed amount, coinsurance for out-of-network providers (UMP), charges for non-covered services do not apply to out-of-pocket maximum. Non-covered services include, but are not limited to member costs above the vision and hearing aid hardware maximums.

[2] Contact your plan about copays and limits for children's vision care.

The information in this document is accurate at the time of printing. Please contact the plans or review the certificate of coverage before making decisions.

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA | BLUE CROSS

See Outlines of Coverage sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

Basic Benefits included in all plans:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require subscribers to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

Plan A	Plan B	Plan C	Plan D	Plan F & Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Hospitalization & preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization & preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits, including 100% Part B coinsurance	Basic including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of pocket limit $4,940 paid at 100% after limit reached	Out of pocket limit $2,470 paid at 100% after limit reached		

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,140 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed $2,140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2014)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan F $106.37	Plan F $206.52	Plan F $200.31	Plan F $400.62

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan F $196.74	Plan F $387.26	Plan F $340.52	Plan F $681.04

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The Group policy is the insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to 7001 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do *NOT* cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

F PLAN F: MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st through 90th day	All but $304 a day	$304 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $152 a day	Up to $152 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the plan's Basic Benefits. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F (continued):

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

MEDICARE (PARTS A & B)

HOME HEALTH CARE - Medicare approved services			
Medically Necessary Skilled Care Services and Medical Supplies	100%	$0	$0
Durable Medical Equipment			
First $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Selecting a PEBB Dental Plan

You have three dental plans to choose from:

- **Uniform Dental Plan (UDP) (preferred-provider plan)**
- **DeltaCare (managed-care plan)**
- **Willamette Dental Group Plan (managed-care plan)**

How DeltaCare and Willamette Dental Group plans work

DeltaCare and Willamette Dental Group are managed-care plans. This means you must select and receive care from a primary care provider in that plan's network or, as needed, receive a referral from your provider to see a specialist. You may change providers within your selected plan's network any time during the year. DeltaCare is administered by Delta Dental of Washington, and its network is **DeltaCare PEBB (Group 3100)**. Willamette Dental Group administers its own dental network.

These plans don't have an annual deductible, so you don't have to keep track of how much you have paid out of pocket before the plan begins covering benefits. And you pay a set amount (called a copay) when you receive dental services. DeltaCare and Willamette Dental Group also do not have an annual maximum that they pay for covered benefits (some specific exceptions apply).

How Uniform Dental Plan works

UDP is a preferred-provider organization (PPO) plan. With this plan, you can choose any dental provider and can change providers at any time.

UDP is also administered by Delta Dental of Washington, and its network is **Delta Dental PPO (Group 3000)**. When you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network.

Under UDP, you pay a percentage of the plan's allowed amount (called coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of $1,750 for covered benefits for each enrolled family member, including preventive visits.

Before you select a plan or provider

1. Confirm that a specific provider is within a dental plan's network. The provider can tell you if his or her practice is "in-network" for your plan.
2. Call the dental plan's customer service (listed in the front of this booklet) or use their online provider directory to confirm whether the provider is in-network for your plan.
3. Make sure you correctly identify your dental plan's network. For example, mention PEBB Group 3000 if you want to enroll in UDP, or Group 3100 if you want to enroll in DeltaCare.
4. Confirm the selection you've made on your enrollment form before you submit it. Did you want a preferred-provider or a managed-care plan?

Note: Delta Dental of Washington administers both UDP and DeltaCare but each plan offers different networks. How much you pay for services depends on the specific provider network for your dental plan.

Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the dental plans directly.

Annual Costs	Preferred-Provider Plan	Managed-Care Plans	
	Uniform Dental Plan (UDP) *(Group 3000 Delta Dental PPO)*	**DeltaCare** *(Group 3100)*	**Willamette Dental Group**
Deductible	$50/person, $150/family	None	
Plan maximum (See specific benefits maximums below.)	You pay amounts over $1,750	No general plan maximum	

Benefits	Preferred-Provider Plan	Managed-Care Plans	
	Uniform Dental Plan (UDP) *(Group 3000 Delta Dental PPO)*	**DeltaCare** *(Group 3100)*	**Willamette Dental Group**
	You pay after deductible	**You pay**	
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower	
Endodontics (root canals)	20% PPO and out of state; 30% non-PPO	$100 to $150	
Nonsurgical TMJ	30% of costs until plan has paid $500 for PPO, out of state, or non-PPO; then any amount over $500 in member's lifetime	**DeltaCare:** 30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member's lifetime **Willamette Dental Group:** Any amount over $1,000 per year and $5,000 in member's lifetime	
Oral surgery	20% PPO and out of state; 30% non-PPO	$10 to $50 to extract erupted teeth	
Orthodontia	50% of costs until plan has paid $1,750 for PPO, out of state, or non-PPO, then any amount over $1,750 in member's lifetime	Up to $1,500 copay per case	
Orthognathic surgery	30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of costs until plan has paid $5,000; then any amount over $5,000 in member's lifetime	
Periodontic services	20% PPO and out of state; 30% non-PPO	$15 to $100	
Preventive/diagnostic (deductible doesn't apply)	$0 PPO; 10% out of state; 20% non-PPO	$0	
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175	
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50	

Life Insurance

Eligibility

Eligibility is the same as for medical and dental plans, **except retiree term life insurance is only available to those who**:

- Meet the PEBB Program's retiree eligibility requirements and had life insurance through the PEBB Program as an employee; **or**
- Are a retiree of an eligible employer group, K-12 school district, or educational service district who had life insurance through the PEBB Program as an active employee; **and**
- Are not on a waiver of premium due to disability.

Your dependents are not eligible for retiree term life insurance.

If you enroll in COBRA between the time you have PEBB employee coverage and the time you become eligible for PEBB retiree coverage, you cannot enroll in retiree term life insurance. The PEBB Program does not offer life insurance to COBRA enrollees and you cannot have a break in life insurance coverage.

Amount of insurance

The amount of insurance paid to your beneficiary is based on your age at the time of death, according to the following schedule:

Age at death	Amount of insurance
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

This insurance has no cash value.

Premium cost

The cost is $6.57 per month, regardless of age. Rates are guaranteed until December 31, 2014.

Enrollment

Complete the *Retiree Coverage Election Form* and return it to the PEBB Program **no later than 60 days** after your employer-paid coverage ends. There are no plans for future open enrollment periods for this life insurance coverage.

Effective date

If you enroll when eligible and pay premiums on time, insurance becomes effective on your retirement date.

No exclusions

This plan covers death from any cause.

Disability

If you become disabled after the effective date of this insurance, you must continue making premium payments to keep your insurance in force.

Beneficiary

You may name any beneficiary you wish when you complete the enrollment form. If you should die with no named living beneficiary, payment will be made to your survivors in this order:

(1) Spouse/state-registered domestic partner
(2) Children
(3) Parents
(4) Estate

If you are married and wish to name someone other than your spouse/state-registered domestic partner as beneficiary, or if you have special estate planning needs, you should seek legal and tax advice before completing your beneficiary designation.

Claim filing

If you die, your beneficiary should submit a certified death certificate as soon as possible to ING Life Claims, P.O. Box 1548, Minneapolis, MN 55440-1548, or call them at 1-866-689-6990. Your beneficiary should also notify the PEBB Program of your death. We may share this information with the Department of Retirement Systems to better serve your survivors.

Insurance certificate

This is a brief summary of the retiree term life insurance plan. If you would like a copy of the complete insurance certificate, contact the PEBB Program at 1-800-200-1004 or P.O. Box 42684, Olympia, WA 98504-2684. This insurance is provided by ReliaStar Life Insurance Company, a member of the ING U.S. family of companies.

Long-Term Care Insurance

The PEBB Program sponsors a voluntary group long-term care insurance plan for:

- Employees who are eligible for PEBB benefits.
- Retirees who are eligible for PEBB benefits.
- Spouses and state-registered domestic partners (including surviving spouses of eligible employees).
- Parents and parents-in-law (under issue age 80 on the coverage effective date) of eligible employees.

John Hancock Life Insurance Company (U.S.A.) is the underwriter for the group long-term care insurance plan (licensed in all states except New York; permitted in New York to service existing insureds and clients).

Family members must be issue age 18 or older to apply for coverage. All applicants must reside in the U.S. (50 states and District of Columbia) on the date they apply and the coverage effective date. This does not apply to employees and their spouses or state-registered domestic partners temporarily residing outside of the U.S. applying with their U.S. residence address. (All certificates will be mailed to a U.S. address.)

Why should I apply for long-term care insurance?

The need for long-term care can occur at any point during your life due to illness, accident, or the effects of aging.

Long-term care insurance covers services at home, in a nursing home setting, and other types of facilities. The mix of care settings and levels of care varies with different policies.

Who helps coordinate what type of care is needed?

John Hancock's care coordinators are registered nurses or licensed social workers who are knowledgeable in long-term care. They will work with you and your family to find the care that is right for you and help you use your long-term care benefits wisely. However, you are not required to follow their recommendations.

What are some features of the long-term care insurance plan?

- **Premiums are based on your age at time of enrollment**—Your age when your coverage becomes effective determines your monthly premium rate. The younger you are when you enroll, the lower your cost will be.
- **Inflation protection feature**—This allows you to increase your coverage periodically, so that it helps keep pace with inflation. You can choose to accept or decline each inflation addition offer, allowing you to determine how much coverage you need.
- **Easy premium payment methods**—You have the option to pay premiums through direct billing or automatic bank withdrawal.
- **Full portability of coverage**—Even if you leave your job and are no longer eligible for PEBB benefits, you can continue your coverage at group rates.

How do I apply?

A retiree, his or her spouse or state-registered domestic partner, parent, parent-in-law, or surviving spouse may apply for long-term care insurance at any time by providing proof of good health. Proof of good health and approval for coverage by the carrier are required to enroll in long-term care insurance.

To request an enrollment kit from John Hancock Life Insurance Company (U.S.A.), you can either:

- Visit PEBB's group long-term care website at **http://pebbltc.jhancock.com** (user name: **pebbltc** password: **jhancock)**, or
- Call John Hancock Life Insurance Company (U.S.A) at 1-800-399-7271.

This is only a brief summary of some of the features of the PEBB group long-term care insurance plan. Some plan features vary by state. More details about plan provisions and exclusions are available from John Hancock.

Auto and Home Insurance

The PEBB Program offers voluntary group auto and home insurance through its alliance with Liberty Mutual Insurance Company—one of the largest property and casualty insurance providers in the country.

What does Liberty Mutual offer?

For PEBB members, this means a group discount of up to 12 percent off Liberty Mutual's auto and home insurance rates. In addition to the discount, Liberty Mutual also offers:

- **Discounts** based on your driving record, age, auto safety features, and more.
- **A 12-month guarantee** on our competitive rates.
- **Convenient payment options**—including automatic payroll deduction (for employees), electronic funds transfer (EFT), or direct billing at home.
- **Prompt claims service** with access to local representatives.

When can I enroll?

You can choose to enroll in auto and home insurance coverage at any time.

How do I enroll?

To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (be sure to have your current policy handy):

- Visit PEBB's website at **www.hca.wa.gov/pebb/pages/auto_home.aspx**
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB member (client #8246).
- Call or visit one of the local offices (see box).

If you are already a Liberty Mutual policyholder and would like to save with Group Savings Plus, just call one of the local offices to find out how they can convert your policy at your next renewal.

Note: Liberty Mutual does not guarantee the lowest rate to all PEBB members; rates are based on underwriting for each individual. Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.

Contact a local Liberty Mutual office (mention client #8246):

Federal Way	**1-800-826-9183** 33915 1st Way S Suite 203 Federal Way, WA 98003
Redmond	**1-800-253-5602** 15809 Bear Creek Parkway #120 Redmond, WA 98052
Spokane	**1-800-208-3044** 16201 E Indiana Ave., Suite 2280 Spokane, WA 99206
Tukwila	**1-800-922-7013** 14900 Interurban Ave., Suite 142 Tukwila, WA 98168
Tumwater	**1-800-319-6523** 300 Deschutes Way SW, Suite 210 Tumwater, WA 98501
Portland, OR	**1-800-248-8320** 650 NE Holladay St. 2nd Floor Portland, OR 97232
Outside WA	**1-800-706-5525**

Valid Dependent Verification Documents

For retirees not on Medicare and any subscriber enrolling a state-registered domestic partner:

Use the list below to determine which verification document(s) to submit with your enrollment form. You may submit one copy of your tax return if it includes all family members that require verification, such as your spouse and children.

Copy of document(s) needed if enrolling a spouse (choose one option):

- The most recent year's 1040 Married Filing Jointly federal tax return that lists the spouse (black out financial information and dependents' Social Security numbers)
- The subscriber's and spouse's most recent 1040 Married Filing Separately federal tax return (black out financial information and dependents' Social Security numbers)
- Proof of common residence (for example, a utility bill) and marriage certificate*
- Proof of financial interdependency (for example, a bank statement—black out financial information) and marriage certificate*
- Petition for dissolution of marriage (divorce)
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration

Copy of document(s) needed if enrolling based on a state-registered domestic partnership or legal union (choose one option):

- Proof of common residence (for example, a utility bill) and certificate/card of state-registered domestic partnership*
- Proof of financial interdependency (for example, a bank statement—black out financial information) and certificate/card of state-registered domestic partnership*
- Petition for invalidity (annulment) of domestic partnership or legal union
- Petition for dissolution of domestic partnership or legal union
- Legal separation notice of domestic partnership or legal union

Copy of document(s) needed if enrolling children (choose one option):

- The most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter (black out financial information and dependents' Social Security numbers)
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration

* If within two years of marriage or state-registered domestic partnership, then only the marriage certificate or certificate/card of state-registered domestic partnership is required.

** If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner to enroll the child, even if not enrolling the spouse/partner in PEBB coverage

Completing the Retiree Forms

Please use dark ink to complete the form(s).

New enrollment

Step 1: Check the "2014 Medical Plans Available by County" section in this guide to find the plans available to you.

Step 2: Locate your plan choice in the column on the right and complete the appropriate form(s).

Step 3: Be sure to include all eligible family members you wish to enroll.

Mail your forms

Complete, sign, and date the form(s) and mail them to:

Washington State
Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

Note: If you or any covered dependents haven't sent us a copy of your Medicare card(s), please send it along with your form(s).

If you are not enrolled in Medicare, or to enroll a domestic partner, you must also provide documents that prove the dependent's eligibility.

If you have questions about the enrollment process, please call us at **1-800-200-1004**.

If sending payment with your form(s), please enclose your check or money order payable to Health Care Authority and mail to:

Washington State
Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Changing enrollment

Step 1: If you're changing medical or dental plans or adding family members to your coverage, fill out the *Retiree Coverage Election Form* (form A).

Step 2: If you are changing medical plans, check the "2014 Medical Plans Available by County" section in this guide to find the plans available to you.

Step 3: Locate your plan choice in the column on the right and complete the appropriate form(s).

If you are currently enrolled in a Medicare Advantage plan and change to a plan that is not a Medicare Advantage plan, you will also need to complete a *PEBB Medicare Advantage Plan Disenrollment Form* (form D). You can download this form from **www.hca.wa.gov/pebb** or call the PEBB Program to request one.

Note: If you're adding a state-registered domestic partner to your coverage and completing form C, he or she should fill out the "spouse" sections. You must also provide copies of documents that prove eligibility for your domestic partner.

If you're adding a state-registered domestic partner, or a domestic partner's child to your coverage, you must also complete and submit the *Declaration of Tax Status* form. You can download this form from our website or call the PEBB Program to request one.

Form A

Use form A only to enroll in or make changes to these plans.

Group Health Classic, Medicare Plan (Original Medicare), or Value

Group Health Options, Inc. (CDHP)

Kaiser Permanente Classic or CDHP

Uniform Medical Plan Classic or UMP CDHP

Forms A and C

Use forms A and C to enroll in or make changes to these plans.

Group Health Medicare Advantage

Kaiser Permanente Senior Advantage

Forms A and B

Use forms A and B to enroll in or make changes to this plan.

Medicare Supplement Plan F, administered by Premera Blue Cross

Enrollment Forms

2014 Retiree Coverage Election Form (form A)
http://www.hca.wa.gov/pebb/documents/51-403F-2014.pdf

Group Medicare Supplement Plan Enrollment Application (form B)
http://www.hca.wa.gov/pebb/documents/premeraB.pdf

Medicare Advantage Plan Election Form (form C)
http://www.hca.wa.gov/pebb/documents/51-576-2014.pdf

Electronic Debit Service Agreement
http://www.hca.wa.gov/pebb/documents/42-450-2013.pdf